UNIVERSITY OF GUAM
UNIBETSEDÅT GUAHAN

EEO/ADA & TITLE IX OFFICE

Employee Request for Disability Accommodation and Services

Name: _____ Date: _____

Contact Information: _____

1. What is your disability? Please specify the date your disability commenced and its expected duration.

2. What is the reasonable accommodation(s) that you are requesting? Be as clear and specific as possible.

3. Please explain how the requested accommodation, aid or assistance measure will help you.

4. Please explain if there are **other** accommodations, aids or assistance measures which may assist you.

5. Are there any elements that you cannot complete **without** the accommodation you are requesting? If so, please explain.

6. Are there any elements that you cannot complete **even with** the accommodation you are requesting?

T: +1 671.735.2244 F: +1 671.734.0430 TDD: +1 671.735.2243 E: eeo-ada@triton.uog.edu
W: www.uog.edu
Mailing Address: 303 University Drive UOG Station Mangilao, Guam 96913

I, _____, request that the above accommodations be provided to me as an individual with a disability, as defined by law and qualified to meet the fundamental requirements and aspects, without undue hardship.

The information that I have provided is true, correct, and complete. I hereby authorize, _____, my treating physician and/or other related health care professional(s) to provide information regarding my condition.

_____ _____

Signature **Date**

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Health Care Professional Section

(Please attach additional pages and supporting documents, if necessary.)

Employee's Name: _____

1. Please complete the Verification of Disability portion or note here if the employee is **not** a qualified person with a disability.

2. Please identify the specific diagnosis and description of the above-named employee's disability, to include the date the disability commenced and its expected duration.

3. What is the reasonable accommodation(s) that you are recommending? Be as clear and concise as possible.

4. Please explain how the requested accommodation, aid or assistance measure will be effective in enabling the employee to perform his/her duties at the University.

5. Please explain if there are **other** accommodations, aids or assistance measures that will enable the employee to perform his/her responsibilities as an employee of the University.

6. Are there any elements of the employee's position that he/she cannot complete **without** this accommodation? If so, please explain.

7. Are there any elements of the employee's position that he/she cannot complete **even with** this accommodation? If so, please explain.

_____ _____

Name of Health Care Professional **Date**

_____ _____

Signature of Health Care Professional **Date**

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Physician's Disability Certification

This is a certification that the named individual below, was determined by a physician to have met the Americans with Disabilities Act (ADA) definition of an "individual with disability (ies)'' in accordance with the ADA disability criteria below:

Name: _____

Date of Birth: _____

_____ Has a physical and/or mental impairment that substantially limits one or more of the major life activities of the individual.

_____ Has a record of such impairment; and/or

_____ Be regarded as having such an impairment.

PHYSICIAN USE ONLY

Disability _____

____Permanent ____Temporary _____
(Length of Certification)

Name of Physician: _____

Address: _____

Contact Number(s): _____

Physician's Signature: _____ _____
Date

Physician or Clinic Stamp: _____

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